CHAPTER 2
ADDENDUM E

DATA REQUIREMENTS - OTHER SPECIAL PROCEDURE CODES

FIGURE 2-E-1 PROCEDURE CODES FOR OUTPATIENT HOSPITAL, AMBULATORY SURGICAL CENTER, BIRTHING CENTER, AND HOSPITAL/OUTPATIENT BIRTHING ROOM CLAIMS

Contractors are to use the following hierarchy to code outpatient hospital claims:

1. Use CPT-4 procedure codes[1] if the services to be coded are physical therapy (97010 - 97799) or speech therapy (92507 - 92508).
2. In addition to valid CPT procedure codes[1], Psychiatric is included in Figure 2-E-6.
3. The appropriate CPT[1]/HCPCS codes are to be used when available. This would apply to, but not limited to radiology and laboratory charges.
4. Use the following procedure codes if above codes, are not appropriate:

DESCRIPTION OF PROCEDURE	CODES[1]
Radiology Charge	76499
Laboratory Charge	84999
Whole Blood Charges	90593
Recovery Room Charge	90596
Operating Room Charge	90597
Emergency Room Charge	90599
Unlisted Pulmonary Services or Procedure	94799
Medical/Surgical Supplies and Devices	99070
Other Room, Ancillary and Drug Charges	99088
Birthing Center - All-Inclusive Charge - Complete	99590
Birthing Center - All-Inclusive Charge - Partial	99591
Hospital Outpatient Birthing Room Charges	99592

5. For ambulatory surgery claims, charges for x-rays, laboratory fees, physicians' fees, anesthesia services, and other identifiable charges need not be itemized by hospitals. If these services are itemized, contractors need not report the itemization to TMA. Bills must be itemized for birthing center, and hospital-outpatient birthing room and Ambulatory Surgery claims. Codes[1] 99590, 99591 (to be used when birthing center bill is not for all inclusive maternity care because the woman was discharged prior to delivery),

and 99592 may only be used for the services described. The charges reported for the codes for complete or partial birthing center charges and for hospital outpatient birthing rooms are **aggregate amounts.**

FIGURE 2-E-2 DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

DESCRIPTION OF PROCEDURE	LEVEL III CODES[1] PURCHASES
These HCPCS Level III codes must be used when submitting payment records containing procedures for purchase of the following durable medical equipment and medical supplies.	
Chemotherapy Equipment and Supplies (excluding Drugs)	06892
Flutter Device for use in Cystic Fibrosis	06952
Therapeutic Shoes	06954
Wigs and Hairpieces	09977
NOTE: When multiple units are used in a single episode of care, such as one box of twelve syringes, code only one (1) supply or service.	

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FIGURE 2-E-3 SPECIAL PROCEDURAL CODES

DESCRIPTION OF PROCEDURE	LEVEL III CODES[1]
The following are special codes that are valid and payable	
Extracorporeal Immunoadsorption (ECI) With Protein A Columns	36526
Combined Liver-Kidney Transplant	47150
Services of a Home Health Aide/Homemaker (If code 90l99 is used, Special Processing Flag must be 6.)	90199
Drugs; the procedure code to be used for all Drug TED Records (Program Indicator = "D")	98800
Prescription Medical Necessity Reviews	000MN
Prescription Prior Authorizations	000PA
Combined Small Intestine - Liver Transplant	47155
Multivisceral Transplant	44250
Small Intestine Transplant	44701

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FIGURE 2-E-4 SPECIAL STATISTICAL TRACKING CODES

DESCRIPTION OF PROCEDURE	LEVEL III CODES[1]
The following codes are not approved for payment authorization, but reporting them is required for TMA statistical purposes. These codes may only be used when amount allowed dollars in the line item portion of the TED Record are zero.	
Invitro Bone Marrow Processing (Purging)	38298
Non-covered Refractive Services which are rendered as part of an eye examination (that part of an eye examination to evaluate the patient's functional vision)	92190
Supervision of Treatment Team for Outpatient Care, Inpatient Care or Partial Hospital Care; e.g., day or night care, including occupational or recreational therapists, psychologists, custodial physicians, or psychiatric nurses - 50 minutes	92845
Marathon Therapy	92860
Non-covered, nonadjunctive dental services	98691

FIGURE 2-E-5 CPT-4 CODE FOR ANESTHESIA SERVICES

DESCRIPTION OF PROCEDURES	LEVEL I CODES[1]
The following CPT-4 codes shall be used when submitting payment records to TMA for anesthesia services for dates on or after 11/01/1997.	
Anesthesia Codes:	00100 - 01999 (except 01996) 99100 - 99140

NOTE: Prior to 11/01/1997, contractors shall report the surgical procedure codes with an anesthesia related provider specialty code.

FIGURE 2-E-6 MENTAL HEALTH PROCEDURE CODES

DESCRIPTION OF PROCEDURE	LEVEL III CODES[1]
PARTIAL HOSPITALIZATION	
Outpatient services provided in a group setting by a Substance Use Disorder Rehabilitation Facility.	90834
DATA REQUIREMENTS FOR PARTIAL HOSPITALIZATION PRIOR TO FEBRUARY 1, 2007	
Partial Hospitalization, all-inclusive per diem payment for alcohol rehabilitation, 6 hours or more	92891
Partial Hospitalization, all-inclusive per diem payment for alcohol rehabilitation, 3-5 hours (half day program)	92892
Partial Hospitalization, Night Time Care (reimbursement not to exceed amount allowed for half day)	92893
Psychiatric Partial Hospitalization, all inclusive per diem payment of nonsubstance abuse partial hospitalization programs of 6 hours or more	92898
Psychiatric Partial Hospital, all-inclusive per diem payment of nonsubstance abuse programs of 3 - 5 hours, (half-day program)	92899
DATA REQUIREMENTS FOR PARTIAL HOSPITALIZATION ON OR AFTER FEBRUARY 1, 2007	
Partial Hospitalization (psych or SUDRF), all inclusive per diem, 6 hours or more (full day program)	H0037
Partial Hospitalization (psych or SUDRF), all inclusive per diem, 3 - 5 hours (half-day program)	H0035
NOTE: The only other service that may be cost-shared, in addition to these codes is the one hour of psychotherapy per day for individual or family therapy (not to exceed five per week) performed by authorized mental health professionals not employed by or contracted with the partial hospitalization facility.	
WRAPAROUND DEMONSTRATION	
Psychiatric in home services (psychotherapy provided in the beneficiary's home)	90892
Brief, time limited, respite services	90893
Therapeutic foster homes (psychotherapy provided in the foster home)	90894
Therapeutic group homes (psychotherapy provided in the group home)	90895
Crisis stabilization in group homes (psychotherapy provided in a group home, patient unstable)	90896
Other residential or nonresidential ancillary mental health services not included in the above codes	90897

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FIGURE 2-E-6 MENTAL HEALTH PROCEDURE CODES (CONTINUED)

DESCRIPTION OF PROCEDURE	LEVEL III CODES[1]
Case Management Services	90898

NOTE: Wraparound Services include nontraditional mental health services that will provide the flexibility needed to assist a child or adolescent to be maintained in the least-restrictive and least-costly setting. This demonstration will be implemented February 1, 1998 and run for two years. Medically necessary institutional care, i.e., provided in a psychiatric hospital, RTC, etc., under this demonstration shall be billed on the appropriate institutional claim form. **All Mental health services both ancillary and institutional shall be coded by Merit Behavioral Corporation (MBC) with the special processing code for this demonstration.**

FIGURE 2-E-7 NEWBORN DIAGNOSIS CODES

DESCRIPTION OF PROCEDURES	CODES
Fetus or newborn affected by complications of placenta, cord and membranes	762.0-779.9
Liveborn births	V30.0-V39.2

FIGURE 2-E-8 OUTPATIENT PROCEDURE CODES

DESCRIPTION OF PROCEDURES	CODES[1]
NONINVASIVE CARDIAC DIAGNOSTIC TEST	93025
OFFICE/Outpatient Visit, New Patient	99201-99205
OFFICE/Outpatient Visit, Established Patient	99211-99215
OFFICE Consultation	99241-99245
VISIT, New Patient	99341-99345
VISIT, Established Patient	99351-99353
NEWBORN CARE, Not In Hospital	99432
HOME INFUSION THERAPY	S5036-S5523

FIGURE 2-E-9 DELIVERY DIAGNOSIS CODES

DESCRIPTION OF PROCEDURES	CODES
Complications mainly related to pregnancy	640-648.9
Normal delivery and other indications for care in pregnancy, labor and delivery	650-659.9
Complications occurring mainly in the course of labor and delivery	660-669.9

FIGURE 2-E-10 PRENATAL AND POSTPARTUM DIAGNOSIS CODES

DESCRIPTION OF PROCEDURES	CODES
Infections of the breast and nipple associated with childbirth	675
Normal pregnancy	V22
Supervision of high-risk pregnancy	V23
Postpartum care and examination	V24
Antenatal screening	V28